

III. CONTRACTOR RESPONSIBILITIES**A. Contractor Receipt and Control of Claims****1. P. O. Box**

The contractor may at its discretion establish a dedicated post office box to receive claims and correspondence related to the Supplemental Health Care Program (SHCP). This dedicated box, if established, may be the same post office box which may be established for handling TRICARE Prime Remote and MTF Referred Care claims, as discussed in [OPM Part Three, Chapter 8](#) and [9](#).

2. Claims Processing**a. Claims Processing and Reporting**

Regardless of who submits the claim, SHCP claims will be processed using the standards in the [OPM Part One, Chapter 1](#), unless otherwise stated in this chapter. The claims tracking and retrieval requirements of [OPM Part One, Chapter 1, Section III.B.1.](#) apply equally to SHCP claims. The contractor for the Region in which the patient resides shall process the claim to completion. Reports on the timeliness of processing SHCP claims, as required under [Section III.I.](#) of this chapter are due to the Lead Agents and SPOC no later than the *fifteenth* (15th) calendar day of the month following the reporting period. Claims for inpatient and outpatient medical services shall be processed to completion without application of a cost-share, co-payment or deductible. Non-availability statements shall not be required.

b. Claims Processing and Reporting in Alaska

The current contractual agreements with the California and Hawaii managed care support contractor provide for administrative services and support to the TRICARE Pacific Support Office Alaska (e.g., TRICARE Service Center support, Health Care Information Line (HCIL) and claims processing). The contractor shall process these claims using the agreed upon interagency rates for reimbursement.

c. Foreign Claims Processing

(1) Process claims received by the contractor for patients covered by reciprocal host nation health care agreements in accordance with the current requirements of the Operations Manual and the Policy Manual.

(2) Forward claims received for personnel permanently assigned to an overseas location to the appropriate overseas claims processor for processing.

3. Contractor Verification**a. Authorization Process For Claims**

The contractor shall perform the following screening steps to determine if a claim may be processed to completion under the provisions of this chapter:

(1) Check for MTF Referral Authorization

If an MTF referral is on file, process the claim in accordance with the provisions of [OPM Part Three, Chapter 9](#).

(2) Check DEERS Status

If the patient is listed in DEERS as direct care eligible, process the claim in accordance with [Section III.B.](#), Types of Care, below. If, in the process of the DEERS check, the contractor determines the ADSM is enrolled in TRICARE Prime Remote, then the claim should be processed as a TRICARE Prime Remote claim in accordance with [OPM Part Three, Chapter 8](#). The contractor for the Region in which the patient resides shall process the claim to completion.

(3) Check for SPOC Preauthorization

If a SPOC preauthorization exists, process the claim to completion in accordance with this chapter whether or not the patient is listed in DEERS.

(4) Check Claim for Attached Documentation

If the patient is listed in DEERS as not direct care eligible, but the claim or its attached documentation indicates potential eligibility (e.g., military orders, commander's letter), pend the case and forward a copy of the claim and attached documentation to the SPOC for an eligibility determination.

(5) Criteria Not Met

If none of the conditions stated above are met, the claim may be returned uncontrolled to the submitting party in accordance with established procedures.

b. Third Party Liability

Third party liability (TPL) processing requirements ([OPM Part Two, Chapter 5](#)) will be applied to all claims covered by this chapter. However, adjudication action on claims will not be delayed awaiting completion of the requisite questionnaire and compilation of documentation. Instead, the claim will be processed to completion and the TPL documentation will be forwarded to the appropriate uniformed service claims office when complete.

B. Types of Care
1. Emergency Care (as defined in Policy Manual, Chapter
1)

Subsequent to the eligibility verification process described in [Section III.A.3.a.](#) above, the contractor shall pay all emergency claims for eligible uniformed Service members. If an emergency civilian hospitalization comes to the attention of the contractor, it shall be reported to the SPOC. The SPOC will have primary case management responsibility, including authorization of care and patient movement for all civilian hospitalizations.

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2. Non-Emergent Care

Subsequent to eligibility verification as described in [Section III.A.3.a.](#) above, the contractor shall verify whether the non-emergent medical civilian health care provided was authorized by the SPOC or HCF. If there is a HCF authorization on file, process the claim in accordance with the provisions of [OPM Part Three, Chapter 9](#). If a required authorization is not on file, then the contractor will place the claim in a pending status and will forward copies of appropriate documentation to SPOC for determination. See [Addendum B](#) for SPOC referral and review procedures.

a. If the SPOC authorizes care, the claim will be processed for payment.

b. If the SPOC determines that the civilian health care was not authorized, the contractor shall follow normal TRICARE requirements for issuing EOBs and summary vouchers.

3. Pharmacy

Claims for prescription pharmacy costs from eligible uniformed service members that are incurred as the result of an episode of care covered by this chapter are authorized for payment by the contractor. Claims unrelated to the episode of care are not covered by this chapter unless specifically authorized by the SPOC and are not authorized for payment by the contractor. If there is a question as to whether the claims are related to a particular episode of care, the contractor shall contact the SPOC. The SPOC has two (2) working days to determine if the pharmacy claim is appropriate for the particular episode of care. If the contractor does not receive the SPOC's response within two (2) work days, the contractor will assume the pharmacy claim is valid and enter the contractor's authorization into the claims processing system and, if required by contract, into the designated CHCS platform. Medications for long-term, chronic preexisting conditions are not covered by this chapter and are not authorized for payment by the contractor, unless specifically authorized by the SPOC. Over-the-counter (OTC) medications are not covered.

C. Coverage

1. Normal TRICARE coverage limitations will not apply to services rendered to SHCP eligible uniformed service members covered by this chapter. Services that have been authorized by the SPOC will be covered regardless of whether they would have ordinarily been covered under TRICARE policy. Occasionally, care may be authorized which was not rendered by a TRICARE authorized provider. Customary TRICARE utilization review and utilization management requirements will not apply.

2. Unlike a normal TRICARE authorization, a SPOC authorization shall be deemed to constitute referral, authorization, eligibility verification, and direction to bypass provider certification and NAS rules. Contractors shall take measures as appropriate to enable them to distinguish between the two authorization types.

D. Medical Records

The current contract requirements for medical records shall also apply to ADSMs in this program. Narrative summaries and other documentation of care rendered (including laboratory reports and X-rays) shall be given to the ADSM for delivery to his/her

PCM and inclusion in his/her military health record. The contractor shall be responsible for all administrative/copying costs. Under no circumstances will the ADSM be charged for this documentation.

E. Reimbursement

1. Allowable amounts are to be determined based upon the TRICARE payment reimbursement methodology applicable to the services reflected on the claim, (e.g. DRGs, mental health per diem, CMAC, or TRICARE network provider discount). Reimbursement for services not ordinarily covered by TRICARE and/or rendered by a provider who cannot be a TRICARE authorized provider shall be at billed amounts.

2. Cost sharing and deductibles shall not be applied to SHCP claims.

3. Eligible uniformed service members who have been required by the provider to make “up front” payment at the time services are rendered will be required to submit a claim to the contractor with an explanation and proof of such payment. The SPOC will issue an authorization to the contractor for payments in excess of CMAC or other applicable TRICARE payment ceilings, provided the SPOC has requested and has been granted a waiver from the Executive Director, TRICARE Management Activity, or designee. Upon verification of any required SPOC authorization the eligible uniformed service member may be reimbursed.

4. In no case shall a uniformed service member be subjected to “balance billing” or ongoing collection action by a civilian provider for emergency or authorized care. If the contractor becomes aware of such situations that they cannot resolve they shall pend the file and forward the issue to the SPOC for determination. The SPOC will issue an authorization to the contractor for payments in excess of CMAC or other applicable TRICARE payment ceilings, provided the SPOC has requested and has been granted a waiver from the Executive Director, TRICARE Management Activity, or designee.

F. End of Processing

1. Explanation of Benefits

An Explanation of Benefits (EOB) shall be prepared for each supplemental health care claim processed, and copies sent to the provider and the patient (uniformed service member) in accordance with normal claims processing procedures. The EOB will also include the following statement, “This is a supplemental health care claim, not a TRICARE claim. Questions concerning the processing of this claim must be addressed to the SPOC.” Any standard TRICARE EOB messages which are applicable to the claim are also to be utilized, e.g., “No authorization on file.”

2. Appeal Rights

The appeals process in OPM Part Three, Chapter 7, *as limited herein*, applies to the Supplemental Care Program. If the care is still denied after completion of a review to verify that no miscoding or other clerical error took place and that the SPOC will not authorize the care in question, the notification of the denial shall include the following statement: “If you disagree with this decision, please contact your Service Point of Contact at (xxx) xxx-xxxx” (insert the appropriate SPOC’s number).

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G. Voucher

The Managed Care Support contractors forward vouchers to the TRICARE Management Activity, Office of Contract Resource Management for reimbursement via letter of credit. The contractor shall report SHCP claims on separate vouchers from TRICARE claims. Emergency SHCP claims will be reported separately from all other SHCP claims. The ADP Manual reflects the correct voucher branch of service to be used for supplemental health care claims.

H. HCSR Submittal

The HCSR data will be submitted to TMA (Acquisition Management and Support) similarly to HCSRs for other types of care. The HCSR data for each claim must reflect the appropriate data elements, including the enrolled MTF DMIS ID code, if any; and the PCM code, if any. The appropriate codes published in the ADP Manual are to be used for supplemental health care claims. MTF DMIS ID codes are to be downloaded from DEERS.

I. Reports for SHCP

1. Required Reports

a. Reports reflecting government dollars paid for all SHCP claims will be prepared and submitted to the SPOC and each Lead Agent every month by branch of service. *The contractor shall produce separate reports for services furnished to members of the Army National Guard. contractors shall submit all reports described below both in hard copy and in electronic media in an Excel format. The contractor shall also prepare a separate report of payment on behalf of non-DoD patients. The contractor shall forward this report to TRICARE Management Activity, Managed Care Support Operations Branch. The contractor shall submit these reports no later than the 15th calendar day of the month following the reporting period. These reports will reflect total care paid, and the total dollar amount contained in data elements (1) through (15), below, and will equal the total amount submitted to TRICARE Management Activity, Contract Resource Management Directorate as vouchers and approved for check release.* For those data elements in items (1) through (15), below, which require a count, the MCS contractor must ensure that no workload is double-counted.

b. Aggregated quarterly reports will be prepared and submitted to each Service Headquarters. These reports will be submitted no later than the 15th calendar day of the month following the close of each fiscal quarter.

c. Data elements to include in the reports are:

- (1)** DMIS ID Code – enrollment MTF
- (2)** Total Number and Dollar Amount of Claims Paid
- (3)** Inpatient Dollars Paid - Institutional
- (4)** Inpatient Dollars Paid - Professional Services
- (5)** Outpatient Dollars Paid - Clinic Visits (Professional and

Ancillary Services)

- (6) Outpatient Dollars Paid - Ambulatory Surgeries/
Procedures – Professional Services
- (7) Outpatient Dollars Paid - Ambulatory Surgeries/
Procedures – Institutional
- (8) Total Admissions/Dispositions
- (9) Total Bed Days/LOS
- (10) Total Ambulatory Surgeries/Procedures, including all
Ancillary
- (11) Total Outpatient Visits, Excluding Ambulatory Surgeries
but including all Ancillary related to the outpatient visits
- (12) MDC/CPT Codes/DRG/ICD-9-CM Codes
- (13) Total Prescription Dollars Paid
- (14) Number of prescriptions by generic drug name
- (15) Other Items Paid

2. Additional Reports

a. The Contractor shall produce monthly pharmacy, workload and timeliness reports for the SHCP. If the Contractor has more than one regional contract, it shall produce separate reports for each contract. The reports cover the period beginning on the first day of the month and closing on the last day of the month. The reports are due on the *fifteenth (15th)* calendar day of the month following the month being reported.

b. The Contractor shall prepare a cover letter when forwarding reports, which shall identify the reports being forwarded, the period being reported, the date the cover letter is prepared by the Contractor, and a Contractor point of contact should there be any questions regarding the reports.

c. Workload Reports

(1) The contractor shall prepare and submit a monthly SHCP claims workload report for each branch of service (to include *Army* National Guard separately), as well as one work load report which shows the cumulative totals for all services. The following data shall be included in the workload reports:

- (a) Beginning Inventory of Uncompleted Claims
- (b) Total Number of New Claims Received
- (c) Total Number of Claims Returned
- (d) Total Number of Claims Processed to Completion
- (e) Ending Inventory of Uncompleted Claims

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NOTE:

Ending inventory of uncompleted claims must equal the beginning inventory of uncompleted claims plus total number of new claims received minus total number of claims returned minus total number of claims processed to completion.

(2) The contractor shall send a copy of the Workload Reports to the TMA, Chief, Contractor Evaluation Office. The contractor shall also send a copy of each Service's monthly report to the respective Service Project Officer identified in [Addendum A](#) and to the SPOC.

d. Timeliness Reports

(1) The contractor shall prepare and submit *a separate monthly cycle time and aging report for SHCP claims, containing the same elements and timeliness breakouts as submitted for other TRICARE claims:*

(2) The contractor shall send a copy of the *SHCP* Timeliness Reports to the Lead Agents; Chief Financial Officer, TMA; and to the Chief, Contractor Evaluation *Office*, TMA.

e. Aging Claims Report

The government intends to take action on all referrals to the SPOC as quickly as possible. To support this objective, the SPOC must be kept apprised of those claims on which the contractor cannot take further action until the SPOC has completed its reviews and approvals. Therefore, no less frequently than once per week, the *contractor* shall forward to the SPOC a report listing those claims which have been pended awaiting SPOC action, and the age of those claims. The age breakouts reported in that report may be based upon the same categories as reported in the monthly cycle time and aging reports sent to TMA, ([OPM Part One, Chapter 3, Addendum A, Figure 1-3-A-3](#)). In the alternative, they may be configured based upon existing workload management reports used internally by the contractor or its subcontractor. The weekly report to the SPOC may consist simply of a copy of the relevant portion of such an internal report if the *contractor* or its subcontractor currently utilizes one.

f. Pharmacy Reports

The contractor shall prepare and submit monthly an SHCP pharmacy report detailing pharmacy claims the contractor paid without a prior authorization in the system for a specific episode of care. This pharmacy report will be prepared for each branch of service as well as one pharmacy report which shows the cumulative totals for all services. The following data elements shall be included in the pharmacy reports:

- (1) DMIS ID Code
- (2) Patient Name
- (3) Patient SSAN (or sponsor SSAN if not available)
- (4) Date of Service

- (5) Principal Diagnosis Code
- (6) Principal Diagnosis Code Description
- (7) Principal CPT-4 Code
- (8) Principal CPT-4 Code Description
- (9) NDC for Pharmacy Claim
- (10) NDC Description for Pharmacy Claim
- (11) Total Pharmacy Dollars Paid

3. SHCP Claims Listing

Throughout the period of the contract, the contractor shall have the ability to produce, when requested by TMA, a hardcopy listing of all SHCP claims processed to completion for any given month(s) to substantiate the contractors SHCP vouchers to TMA. The listing shall include the following data elements: referring DMIS ID code, ICN, patient's SSN, and the date the claim was processed to completion. This list shall be presented in ascending DMIS code order.

J. Contractor's Responsibility to Respond to Inquiries

Inquiries relating to the SHCP need not be tracked nor reported separately from other inquiries received by the Managed Care Support Contractor.

1. Telephonic Inquiries

a. All inquiries to the contractor should come from the MTFs/claims offices, the Service Project Officers, the TMA, or SPOC. However, inquiries may be received from congressional representatives, providers and/or patients. To facilitate this process, the contractor shall provide a specific telephone number, different from the public toll-free number, for inquiries related to the SHCP Claims Program. The line shall be operational and continuously staffed according to the hours and schedule specified in the contractor's TRICARE contract for toll-free and other service phone lines. It is not required to be staffed on the same basis as Health Care Finder lines. It may be the same line as required in support of TRICARE Prime Remote under [OPM Part Three, Chapter 8](#) and may be the same line required under [OPM Part Three, Chapter 9](#).

b. The telephone response standards of [OPM Part One, Chapter 1, Section III.E.3.](#) shall apply to SHCP telephonic inquiries.

(1) Congressional Telephonic Inquiries

The contractor shall refer any congressional telephonic inquiries it receives to the SPOC if the inquiry is related to a *the authorization or non-authorization of* specific claim or episode of treatment. If it is a general congressional inquiry regarding the SHCP claims program, the contractor shall respond or refer the caller as appropriate.

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(2) Provider and Other Telephonic Inquiries

The contractor shall refer provider and any other telephonic inquiries it receives, including calls from the Service member to the SPOC if the inquiry *is related to the authorization or non-authorization* of a specific claim. The contractor shall respond as appropriate to general inquiries regarding the SHCP.

2. Written Inquiries**a. Congressional Written Inquiries**

The contractor shall refer written congressional inquiries to the SPOC if the inquiry is related to *the authorization or non-authorization of* a specific claim or episode of treatment. When referring the inquiry, the contractor shall attach a copy of all supporting documentation related to the inquiry. If it is a general congressional inquiry regarding the SHCP, the contractor shall refer the inquiry to the TMA. The contractor shall refer all congressional written inquiries within 72 hours of identifying the inquiry as relating to the SHCP. When referring the inquiry, the Contractor shall also send a letter to the congressional office informing them of the action taken and providing them with the name, address and telephone number of the individual or entity to which the congressional correspondence was transferred.

b. Provider and Service Member (or MTF Patient) Written Inquiries

The contractor shall refer provider and service member written inquiries to the SPOC.

c. MTF Written Inquiries

The contractor shall refer all written inquiries from the MTF to the SPOC upon receipt of the inquiry.

K. Dedicated SHCP Unit

The contractor may at their discretion establish a dedicated unit for all contractor responsibilities related to processing SHCP claims and responding to inquiries about the SHCP. Regardless of the existence of a dedicated unit, the contractor shall designate a point of contact for Government inquiries related to the SHCP.

